BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Aurelia Maaba Reyes 830 Rolph Street San Francisco, CA 94112 Registered Nurse License No. 451855 Respondent.	Case No. 2007-6 OAH No. N-2006090189

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Board of Registered Nursing as its Decision in the above-entitled matter.

This Decision shall become effective on April 13, 2007.

IT IS SO ORDERED March 14, 2007.

LaTrascine W Tate

Vice-President
Board of Registered Nursing
Department of Consumer Affairs
State of California

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
AURELIA MAABA REYES	Case No. 2007-6
Registered Nurse License No. 451855	OAH No. N2006090189
Respondent.	

PROPOSED DECISION

Administrative Law Judge Ruth S. Astle, State of California, Office of Administrative Hearings, heard this matter in Oakland, California, on January 9, 2007.

Jonathan D. Cooper, Deputy Attorney General, represented complainant.

John L. Fleer, Attorney at Law, represented respondent, who was present.

The matter was submitted on January 9, 2007.

FACTUAL FINDINGS

1. Ruth Ann Terry, M.P.H., R.N., made the accusation in her official capacity as the Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs.

2. On March 31, 1990, the Board issued Registered Nurse License Number 451855 to Aurelia Maaba Reyes (respondent). The license was in full force and effect at all times relevant to this matter and will expire on December 31, 2007, unless renewed.

3. Cisplatin is a "dangerous drug" within the meaning of Business and Professions Code section 4022 in that it requires a prescription under law. Cisplatin is a heavy metal that causes cell death by interfering with cell multiplication. It is commonly used to treat head and neck cancers. It is an intravenous medication usually given in a dose based on body surface area.

4. On June 1, 2004, Patient A.C. was admitted to San Mateo Medical Center (SMMC) for rehabilitation and further treatment after he was diagnosed with advanced

squamous cell carcinoma of the mandible. A.C. had previously had an extensive mandibulectomy/resection of the mandible, lip and neck, followed by reconstructive surgery.

5. On June 24, 2004, A.C.'s oncologist completed a "Chemotherapy Order Form" which set forth the chemotherapy treatment plan. The form contained a handwritten notation ordering Cisplatin treatments. The dose was written in a way which made it difficult to ascertain whether the dose to be administered was 50 mg or 500 mg. The column in the form which called for the Cisplatin dose to be expressed in terms of body surface area was not filled in by the physician. The correct dose was 50 mg.[1]

6. In a type-written treatment note dated July 6, 2004, A.C.'s oncologist stated that A.C. was to receive 50 mg of Cisplatin once per week starting on that date.

7. On July 13, respondent administered Cisplatin to A.C. In the Intake and Output record (IOR), respondent correctly documented the administration of 50 mg of Cisplatin to A.C. However, respondent failed to correct the Medical Administration Record (MAR), which stated that she administered a 500 mg dose of Cisplatin to A.C.[2] Respondent failed to initial the entries on the MAR or sign the form. It was respondent's responsibility to make sure the MAR was correct.

8. The physician's chemotherapy order required, prior to the administration of Cisplatin, that an infusion of normal saline containing potassium chloride and magnesium be administered, followed by an infusion of Mannitol. The order and protocol required that the normal saline be administered at least two hours before the Cisplatin, and the Mannitol about twenty minutes before the Cisplatin. This is done to minimize toxicity to the kidneys.

9. Respondent did not calculate A.C.'s body surface area and verify that the dose was within an acceptable dose range. Respondent did not review A.C.'s prior chemotherapy records prior to administration of Cisplatin.

10. Respondent failed to document an assessment of A.C.'s condition and assess laboratory values as to A.C.'s renal function, blood count and electrolytes before and after administration of Cisplatin to A.C. Respondent also misidentified a gastronomy tube as a colostomy site.

11. It was established by clear and convincing evidence that on July 13, 2004, respondent acted with gross negligence and incompetence in carrying out her nursing functions. The order and timing of the infusion (hydration, mannitol) and then the chemotherapy, is essential for the proper treatment of the patient. Respondent clearly charted that she gave the hydration and chemotherapy at the same time, and that she gave the

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[1] On a later date A.C. was given the wrong dose of Cisplatin (500 mg) by a different nurse, which resulted in the patient's death.

[2] It was established that respondent did give the correct dose to the patient.

mannitol after the chemotherapy. This is clearly an extreme departure from the standard of practice.

Respondent claims that she did the steps in the proper order and with the proper timing. However, her testimony, in that regard, was not credible. The records indicate that the patient arrived in the unit at 9:30 a.m. and that he was given pre-chemotherapy medications at 10 a.m., Cisplatin and hydration at 10:15 a.m., and mannitol at 12:15 p.m. The earliest the Cisplatin should have been infused was at 12 noon. Respondent had been counseled in 1998 about a problem she had giving chemotherapy. At that time she was given an article about chemotherapy that specifically explained that the timing is crucial to minimize damage to the kidneys. Respondent's claim that she did the hydration, mannitol and Cisplatin in the right order and with the right timing is not supported by the record.

Complainant's expert established that it is an extreme departure from the standard of practice to administer the chemotherapy incorrectly.

12. It was established by clear and convincing evidence that on July 13, 2004, respondent made grossly inconsistent and unintelligible entries into patient A.C.'s medical records. The records were so poor as to be essentially unintelligible. While respondent did not actually write the entry that she administered 500 mg of Cisplatin in the MAR, she admitted that the record was her responsibility. She was required to check and correct the MAR.

13. The evidence did not establish whether or not respondent was in violation of SMMC policies when she failed to require the physician to complete the chemotherapy order.

14. In addition to the prior admonishment on July 9, 1998, by SMMC for improperly administering chemotherapy to a patient, respondent was formally reprimanded on May 10, 2000, for incompetence in relation to a patient falling. The reprimand indicates that respondent had received five previous warnings in that year. However, the reasons for these warnings were not established. Respondent believes that the warnings were for her absenteeism and her loud voice, but no documentation of the five prior warnings was offered by either party.

15. Respondent's supervisor, Meriam Nguyen, M.S.N., P.H.N, R.N., Clinical Services Manager, Medical Surgical Services, testified that respondent has a good relationship with patients. She takes time with the patients and gets along well with staff.

She participated in an internal investigation that found respondent's documentation was inappropriate and that she failed to clarify the transcribed order (referring to the MAR).

16. Respondent was required to take a two-day training course at UCSF on chemotherapy. She is now very careful about documentation and SMMC now requires two nurses to check documentation.

17. The potential for harm to a patient created by respondent's lack of documentation and her grossly negligent administration of chemotherapy is extreme. Kidney damage, and ultimately death, can result. Respondent did not present any evidence that she took classes in record keeping. While, it would not be against the public interest to allow respondent to continue to be licensed as a registered nurse on terms and condition of probation, she must take and pass a formal record keeping course.

18. Costs in the amount of $6,057 for prosecution in this matter were requested. Investigative costs in the amount of $4,498 were requested. The total amount of $10,555 is reasonable.

LEGAL CONCLUSIONS

1. By reason of the matters set forth in Findings 3 through 11, cause for disciplinary action exists pursuant to Business and Professions Code section 2761, subdivision (a)(1) (Unprofessional conduct - gross negligence/incompetence). Respondent acted with gross negligence in carrying out her nursing duties.

2. By reason of the matters set forth in Findings 3 through 10 and 12, cause for disciplinary action exists pursuant to Business and Professions Code section 2762, subdivision (e) (grossly inconsistent, grossly incorrect, or unintelligible record entries). Respondent's record entries were grossly inconsistent, grossly incorrect and unintelligible.

3. The matters set forth in Finding 13 did not establish cause for disciplinary action. The policies of SMMC do not serve as a basis for disciplinary action.

4. The matters in aggravation, mitigation, extenuation and rehabilitation set forth in Findings 14 through 17, have been considered in making the following order.

5. Cost recovery in the amount of $10,555 is reasonable and is ordered below pursuant to Business and Professions Code section 125.3.

ORDER

Registered Nurse license number 451855 issued to Aurelia Maaba Reyes is hereby revoked. However, the revocation is stayed for a period of three (3) years upon the following terms and conditions:

SEVERABILITY CLAUSE – Each condition of probation contained herein is a separate and distinct condition. If any condition of this Order, or any application thereof, is declared unenforceable in whole, in part, or to any extent, the remainder of this Order, and all other applications thereof, shall not be affected. Each condition of this Order shall separately be valid and enforceable to the fullest extent permitted by law.

1. OBEY ALL LAWS - Respondent shall obey all federal, state and local laws. A full and detailed account of any and all violations of law shall be reported by respondent to the Board in writing within seventy-two (72) hours of occurrence. To permit monitoring of compliance with this condition, respondent shall submit completed fingerprint forms and fingerprint fees within 45 days of the effective date of the decision, unless previously submitted as part of the licensure application process.

2. COMPLY WITH THE BOARD'S PROBATION PROGRAM Respondent shall fully comply with the conditions of the Probation Program established by the Board and cooperate with representatives of the Board in its monitoring and investigation of respondent's compliance with the Board's Probation Program. Respondent shall inform the Board in writing within no more than 15 days of any address change and shall at all times maintain an active, current license status with the Board, including during any period of suspension.

   Upon successful completion of probation, respondent's license shall be fully restored.

3. REPORT IN PERSON - Respondent, during the period of probation, shall appear in person at interviews/ meetings as directed by the Board or its designated representatives.

4. RESIDENCY, PRACTICE, OR LICENSURE OUTSIDE OF STATE - Periods of residency or practice as a registered nurse outside of California shall not apply toward a reduction of this probation time period. Respondent's probation is tolled, if and when she resides outside of California. Respondent must provide written notice to the Board within 15 days of any change of residency or practice outside the state, and within 30 days prior to re-establishing residency or returning to practice in this state. Respondent shall provide a list of all states and territories where she has ever been licensed as a registered nurse, vocational nurse, or practical nurse. Respondent shall further provide information regarding the status of each license and any changes in such license status during the term of probation. Respondent shall inform the Board if she applies for or obtains a new nursing license during the term of probation.

5. SUBMIT WRITTEN REPORTS - Respondent, during the period of probation, shall submit or cause to be submitted such written reports/declarations and verification of actions under penalty of perjury, as required by the Board. These reports/declarations shall contain statements relative to respondent's compliance with all the conditions of the Board's Probation Program. Respondent shall immediately execute all release of information forms as may be required by the Board or its representatives.

   Respondent shall provide a copy of this decision to the nursing regulatory agency in every state and territory in which he or she has a registered nurse license.

6. FUNCTION AS A REGISTERED NURSE - Respondent, during the period of probation, shall engage in the practice of registered nursing in California for a minimum of 24 hours per week for 6 consecutive months or as determined by the Board.

   For purposes of compliance with the section, "engage in the practice of registered nursing" may include, when approved by the Board, volunteer work as a registered nurse, or work in any non-direct patient care position that requires licensure as a registered nurse.

   The Board may require that advanced practice nurses engage in advanced practice nursing for a minimum of 24 hours per week for 6 consecutive months or as determined by the Board.

   If respondent has not complied with this condition during the probationary term, and the respondent has presented sufficient documentation of his or her good faith efforts to comply with this condition, and if no other conditions have been violated, the Board, in its discretion, may grant an extension of the respondent's probation period up to one year without further hearing in order to comply with this condition. During the one year extension, all original conditions of probation shall apply.

7. EMPLOYMENT APPROVAL AND REPORTING REQUIREMENTS - Respondent shall obtain prior approval from the Board before commencing or continuing any employment, paid or voluntary, as a registered nurse. Respondent shall cause to be submitted to the Board all performance evaluations and other employment related reports as a registered nurse upon request of the Board.

Respondent shall provide a copy of this decision to his her employer and immediate supervisors prior to commencement of any nursing or other health care related employment.

In addition to the above, respondent shall notify the Board in writing within seventy-two (72) hours after she obtains any nursing or other health care related employment. Respondent shall notify the Board in writing within seventy-two (72) hours after he or she is terminated or separated, regardless of cause, from any nursing, or other health care related employment with a full explanation of the circumstances surrounding the termination or separation.

8. SUPERVISION - Respondent shall obtain prior approval from the Board regarding respondent's level of supervision and/or collaboration before commencing or continuing any employment as a registered nurse, or education and training that includes patient care. Respondent shall practice only under the direct supervision of a registered nurse in good standing (no current discipline) with the Board of Registered Nursing, unless alternative methods of supervision and/or collaboration (e.g., with an advanced practice nurse or physician) are approved.

Respondent's level of supervision and/or collaboration may include, but is not limited to the following:

(a) Maximum - The individual providing supervision and/or collaboration is present in the patient care area or in any other work setting at all times.

(b) Moderate - The individual providing supervision and/or collaboration is in the patient care unit or in any other work setting at least half the hours respondent works.

(c) Minimum - The individual providing supervision and/or collaboration has person-to-person communication with respondent at least twice during each shift worked.

(d) Home Health Care - If respondent is approved to work in the home health care setting, the individual providing supervision and/or collaboration shall have person-to-person communication with respondent as required by the Board each work day. Respondent shall maintain telephone or other

telecommunication contact with the individual providing supervision and/or collaboration as required by the Board during each work day. The individual providing supervision and/or collaboration shall conduct, as required by the Board, periodic, on-site visits to patients' homes visited by the respondent with or without respondent present.

9. EMPLOYMENT LIMITATIONS - Respondent shall not work for a nurse's registry, in any private duty position as a registered nurse, a temporary nurse placement agency, a traveling nurse, or for an in-house nursing pool.

Respondent shall not work for a licensed home health agency as a visiting nurse unless the registered nursing supervision and other protections for home visits have been approved by the Board. Respondent shall not work in any other registered nursing occupation where home visits are required.

Respondent shall not work in any health care setting as a supervisor of registered nurses. The Board may additionally restrict respondent from supervising licensed vocational nurses and/or unlicensed assistive personnel on a case-by-case basis.

Respondent shall not work as a faculty member in an approved school of nursing or as an instructor in a Board approved continuing education program.

Respondent shall work only on a regularly assigned, identified and predetermined worksite(s) and shall not work in a float capacity.

If the respondent is working or intends to work in excess of 40 hours per week, the Board may request documentation to determine whether there should be restrictions on the hours of work.

10. COMPLETE A NURSING COURSE(S) - Respondent, at her own expense, shall enroll and successfully complete a course(s) relevant to the practice of registered nursing no later than six months prior to the end of his or her probationary term. This shall include a course on record keeping. Respondent shall obtain prior approval from the Board before enrolling in the course(s). Respondent shall submit to the Board the original transcripts or certificates of completion for the above required

course(s). The Board shall return the original documents to respondent after photocopying them for its records.

11. COST RECOVERY - Respondent shall pay to the Board costs associated with its investigation and enforcement pursuant to Business and Professions Code Section 125.3 in the amount of $10,555. Respondent shall be permitted to pay these costs in a payment plan approved by the Board, with payments to be completed no later than three months prior to the end of the probation term.

If respondent has not complied with this condition during the probationary term, and respondent has presented sufficient documentation of her good faith efforts to comply with this condition, and if no other conditions have been violated, the Board, in its discretion, may grant an extension of the respondent's probation period up to one year without further hearing in order to comply with this condition. During the one year extension, all original conditions of probation will apply.

12. VIOLATION OF PROBATION - If a respondent violates the conditions of her probation, the Board after giving the respondent notice and an opportunity to be heard, may set aside the stay order and impose the stayed discipline (revocation) of the respondent's license.

If during the period of probation, an accusation or petition to revoke probation has been filed against respondent's license or the Attorney General's Office has been requested to prepare an accusation or petition to revoke probation against the respondent's license, the probationary period shall automatically be extended and shall not expire until the accusation or petition has been acted upon by the Board.

13. LICENSE SURRENDER - During respondent's term of probation, if she ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the conditions of probation, respondent may surrender his or her license to the Board. The Board reserves the right to evaluate respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances, without further hearing. Upon formal acceptance of the tendered license and wall certificate, respondent will no longer be subject to the conditions of probation.

Surrender of respondent's license shall be considered a disciplinary action and shall become a part of respondent's license history with the Board. A registered nurse whose license has been surrendered may petition the Board for reinstatement no sooner than the following minimum periods from the effective date of the disciplinary decision:

1. Two years for reinstatement of a license that was surrendered for any reason other than a mental or physical illness; or

2. One year for a license surrendered for a mental or physical illness.

DATED: 1/24/07

Ruth S. Astle

RUTH S. ASTLE
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: AURELIA MAABA REYES 830 Rolph St. San Francisco, CA 94112 Registered Nurse License No. 451855 Respondent.	Case No. 2007-6 OAH No. **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about March 31, 1990, the Board of Registered Nursing issued Registered Nurse License Number 451855 to Aurelia Maaba Reyes (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2007, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

". . ."

7. Section 2762(e) of the Code provides, in pertinent part, that it is unprofessional conduct for a Registered Nurse to make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the administration of controlled substances to a patient.

8. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

9. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

10. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

11. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CISPLATIN

12. Cisplatin is a "dangerous drug" within the meaning of Business and Professions Code section 4022 in that it requires a prescription under federal and/or state law. Cisplatin is a heavy metal that causes cell death by interfering with cell multiplication. It is commonly used to treat head and neck cancers. It is an intravenous medication usually given in a dose based on body surface area.

FACTUAL SUMMARY

13. On or about June 1, 2004, Patient A.C. was admitted to the San Mateo Medical Center (SMMC) for rehabilitation and further treatment after he had been diagnosed with advanced squamous cell carcinoma of the mandible. A.C. had previously had an extensive mandibulectomy/resection of the mandible, lip and neck, followed by reconstructive surgery.

14. On or about June 24, 2004, A.C.'s oncologist completed a "Chemotherapy Order Form" which set forth the chemotherapy treatment plan. The form contained a hand-written notation ordering Cisplatin treatments. The dose was written in a way which made it uncertain whether the dose to be administered was 50 mg or 500 mg. The column in the form which called for the Cisplatin dose to also be expressed in terms of body surface area was not filled in.

15. In a type-written treatment note dated July 6, 2004, A.C.'s oncologist stated that A.C. was to receive 50 mg of Cisplatin once per week starting on that date.

16. On July 6, 2004, A.C. received a 50 mg dose of Cisplatin.

17. On July 13, Respondent administered Cisplatin to A.C. In the Intake and Output record (IOR), Respondent documented administration of 50 mg. of Cisplatin to A.C. However, Respondent documented in the Medical Administration Record (MAR) that she

administered 500 mg of Cisplatin to A.C. Respondent failed to initial or sign either of these entries and forms.

18. The physician's chemotherapy order required, prior to administration of Cisplatin, administration of an infusion of normal saline containing potassium chloride and magnesium followed by an infusion of Mannitol. Instead of following this order, Respondent administered the saline infusion contemporaneously with the Cisplatin, and administered Mannitol after the Cisplatin. Respondent documented administration of these drugs on the IOR and MAR but did not initial or sign these entries and forms.

19. In violation of SMMC policy, Respondent failed to require the physician to complete the chemotherapy order to include a statement of the Cisplatin dose in relation to body surface area as well as the total dose to be infused prior to using the order as the basis for chemotherapy administration. Also in violation of SMMC policy, Respondent did not contact the physician to discuss whether the proper dose was 50 mg or 500 mg.

20. In violation of SMMC policy, Respondent did not calculate A.C.'s body surface area (BSA) and verify that the dose was within an acceptable dose range.

21. Respondent did not review A.C.'s prior chemotherapy records prior to administration of Cisplatin.

22. Respondent failed to document an assessment of A.C.'s condition and assess laboratory values as to A.C.'s renal function, blood count and electrolytes before and after administration of Cisplatin to A.C. Respondent also mis-identified a gastronomy tube as a colostomy site.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence/Incompetence)

23. Respondent is subject to disciplinary action under section 2761(a)(1) of the Code in that on or about July 13, 2004, she acted with gross negligence and incompetence in carrying out her nursing functions, as outlined above in paragraphs 13 - 22.

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SECOND CAUSE FOR DISCIPLINE

(Grossly Inconsistent Record Entries)

24. Respondent is subject to disciplinary action under section 2762(e) of the Code in that on or about July 13, 2004, she entered grossly inconsistent entries into a patient's medical records, as set forth above in paragraph 17.

OTHER MATTERS

25. On or about July 9, 1988, Respondent was formally admonished by SMMC for improperly administering chemotherapy to a patient.

26. On or about May 10, 2000, SMMC formally reprimanded Respondent for incompetence after Respondent had received five previous warnings in that year.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse, License Number 451855, issued to Aurelia Maaba Reyes;

2. Ordering Aurelia Maaba Reyes to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 7/14/06

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant